THE OFFICE OF CONTRACTING AND PROCUREMENT

NOTICE OF EMERGENCY RULEMAKING

The Chief Procurement Officer of the District of Columbia ("CPO"), pursuant to authority granted by sections 202, 204 and 1103(b) of the District of Columbia Procurement Practices Act of 1985 ("PPA"), effective November 13, 2003, D.C. Law 15-39, D.C. Official Code §§ 2-302.02, 2-302.04 and 2-311.03(b) (2006 Repl.), and Mayor's Order 2002-207, dated December 18, 2002, hereby gives notice of the adoption on July 18, 2007 of the following amendment to Chapter 21 of Title 27 of the District of Columbia Municipal Regulations (Contracts and Procurements). This rulemaking is intended to amend Chapter 21 of Title 27 D.C. Municipal Regulations ("DCMR"), which chapter concerns required sources of supplies and services, to establish a sales discount on all sales made under contracts awarded under the District of Columbia's multiple award schedule procurement program, also known as the D.C. Supply Schedule ("DCSS"). The emergency rule will allow the CPO to charge and collect, on a quarterly basis, from contractors awarded contracts in the DCSS, a sales discount in the amount of one percent (1%), on all sales, purchase orders, delivery orders, task orders, and purchase card transactions made under contracts awarded under the DCSS.

The rules were originally adopted as emergency and proposed rules on March 22, 2007 and published in the *D.C. Register* on April 13, 2007, at 54 DCR 3316. The current emergency rules expired on November 15, 2007. The proposed rule has been submitted to the Council of the District of Columbia for its review pursuant to section 205(b) of the PPA (D.C. Official Code § 2-302.05(b)), and will be published in the *D.C. Register* after either Council approval or expiration of a 60-day Council review period. No changes have been made to the rule as originally adopted.

Emergency rulemaking is necessary because, without the rule, the CPO may not charge and collect the sales discount from DCSS contractors, which funds pay the costs of operating the DCSS program. The emergency rule will remain in effect up to one hundred twenty (120) days from date of adoption, unless earlier superseded by another rulemaking notice or by publication of a Notice of Final Rulemaking in the *D.C. Register*.

CHAPTER 21

REQUIRED SOURCES OF SUPPLIES AND SERVICES

Chapter 21, Title 27 DCMR, is amended by adding a new section 2106 to read as follows:

2106 SALES DISCOUNT UNDER MULTIPLE AWARD SCHEDULE PROCUREMENT PROGRAM

2106.1 The Chief Procurement Officer may charge and collect, on a quarterly basis, a sales discount in the amount of one percent (1%), on all sales, purchase orders, delivery orders, task orders, and purchase card transactions invoiced under contracts awarded under the District of Columbia's multiple award schedule procurement program, also known as the District of Columbia Supply Schedule.

All persons desiring to comment on the subject matter of this proposed rulemaking should file comments, in writing, and send them to the Chief Procurement Officer, 441 4th Street, Suite 700 South, Washington, D.C. 20001. Comments must be received no later than thirty (30) days from the date of publication of this notice in the *D.C. Register*. A copy of this proposed rulemaking may be obtained at the same address.

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption, on an emergency basis, of an amendment to repeal Sections 927 (Attendant Care Services), 928 (Adaptive Equipment Services), 938 (Homemaker Services), 939 (Chore Services), 940 (Case Management Services), and 944 (Adult Companion Services) of Chapter 9, "Medicaid Program," to Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR). The repealed sections established standards governing reimbursement by the District of Columbia Medicaid Program for six (6) services that are no longer available as separate services under the Home and Community-based Services Waiver for Persons with Developmental Disabilities (Waiver), which recently was approved by the District of Columbia Council and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), effective November 20, 2007.

This rulemaking repeals section 927 (Attendant Care Services), previously published at 54 DCR 6429 (June 29, 2007); section 928 (Adaptive Equipment Services), previously published at 50 DCR 6175 (August 1, 2003); section 938 (Homemaker Services), previously published at 50 DCR 7832 (September 19, 2003); section 939 (Chore Services), previously published at 50 DCR 6703 (August 15, 2003); section 940 (Case Management Services), previously published at 50 DCR 2042 (March 7, 2003); and section 944 (Adult Companion Services), previously published at 50 DCR 8188 (October 3, 2003). The six repealed sections identify services that are included as a blend of services within the twenty-five (25) Waiver services that are available to participants in the new Waiver as approved by the CMS (*i.e.* Attendant Care Services, Homemaker Services, Chore Services, and Adult Companion), are available under the State Plan for Medical Assistance only (*i.e.* Adaptive Equipment Services), or are no longer reimbursable as a separate service (*i.e.* Case Management Services). Providers must bill the Medicaid Program within 180 days of the date of service for the repealed services, since these services will not be available separately under the Waiver on or after November 20, 2007. Residential Habilitation Services under section 946, Supported Living Services under section 993, and In-Home Supports Services under section 1916, provides a blend of the previously-available services under the former Waiver (*i.e.* Attendant Care Services, Homemaker Services, Chore Services, Adult Companion Services, Personal Care Services under section 1910 and the State Plan for Medical Assistance) that under the new Waiver will be delivered based on the individual habilitation plan or individual supports plan and plan of care developed by the person and his/her support team.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of these six repealed Waiver services. These emergency rules are needed so that, on November 20, 2007, the effective date of the Waiver as modified and approved by CMS, rules are in place consistent with the new Waiver so

participants and providers are able to identify the services available under the approved Waiver.

The emergency rulemaking was adopted on November 19, 2007, and became effective on November 20, 2007. The emergency rules will remain in effect for 120 days or until March 18, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register.*

Section 927 (Attendant Care Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

927 [REPEALED]

Section 928 (Adaptive Equipment Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

928 [REPEALED]

Section 938 (Homemaker Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

938 [REPEALED]

Section 939 (Chore Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

939 [REPEALED]

Section 940 (Case Management Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

940 [REPEALED]

Section 944 (Adult Companion Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

944 [REPEALED]

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, D.C. 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat.744; D.C. Official Code § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption, on an emergency basis, of an amendment to section 946 (Residential Habilitation Services) of Chapter 9 (Medicaid Program) of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR). These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for residential habilitation services provided by qualified professionals to participants with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

This rulemaking amends the rules previously published at 54 DCR 4394 (May 11, 2007). The new residential habilitation services rules provide a blend of the previously-available services under the former Waiver (*i.e.*, Homemaker Services, Chore Services, Adult Companion Services and Personal Care Services). This service delivery approach will address the problems encountered, such as different provider qualifications and restrictions for each service when multiple provider agencies and support staff are needed to deliver supports to Waiver participants. The new rules are intended to resolve staffing issues which have made it difficult to support individuals effectively in group homes. Residential habilitation services is a twenty-four (24) hour service limited to licensed homes which are owned, leased, or otherwise operated by the provider. The reimbursement rates have been modified based on the new rate setting methodology and the collapsing of services into daily rates based on acuity. The acuity system is based on the intensity of staffing required for each group home.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of residential habilitation services. These emergency rules are needed so that, on the effective date of the Waiver as modified, there will be rules in place consistent with the provisions of the Waiver as modified to provide residential habilitation services in licensed or certified group homes based on daily rates that are in turn based on the acuity level of the persons being served.

The District of Columbia Medicaid Program also is modifying the Waiver to reflect these changes. The Council of the District of Columbia has approved the corresponding Waiver. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, has also approved the Waiver with an effective date of November 20, 2007. The emergency rulemaking was adopted on November 19, 2007 and will become effective on November 20, 2007. The emergency rules will remain in effect for 120 days or until March 17, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Section 946 of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

946 RESIDENTIAL HABILITATION SERVICES

946.1 Residential habilitation services shall be reimbursed by the District of Columbia Medicaid Program for each participant in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

946.2 In order to qualify for reimbursement under this section, residential habilitation services shall be provided in a Group Home for Mentally Retarded Persons (GHMRP) or similarly licensed group home in other states. Each GHMRP located in the District of Columbia shall be licensed pursuant to section 3 of the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-502) no later than sixty (60) days after approval as a Medicaid provider and comply with the requirements set forth in Chapter 35 of Title 22 of the District of Columbia Municipal Regulations (DCMR), except as set forth in these rules. In order to qualify for reimbursement under this section, residential habilitation services shall be delivered in a GHMRP or group home licensed or certified in other states that can serve four (4) to six (6) persons.

946.3 Each group home located out-of-state shall be licensed or certified in accordance with the host state's laws and regulations and be consistent with the terms and conditions set forth in an agreement between the District of Columbia and the host state. Each out-of-state provider shall comply with the following additional requirements:

(a) Remain in good standing in the jurisdiction where the program is located;
(b) Submit a copy of the annual certification or survey performed by the host state and provider's corrective action plan, if applicable, to the Department on Disability Services (DDS); and
(c) Allow authorized agents of the District of Columbia government, federal government, and governmental officials of the host state full access to all sites and records for audits and other reviews.

946.4 Residential habilitation services shall only be available to a person with a demonstrated need for continuous training, assistance, and supervision, and shall be authorized and provided in accordance with the person's current Individual Habilitation Plan (IHP) or Individual Support Plan (ISP) and Plan of Care.

946.5 Each provider of residential habilitation services shall assist persons in the acquisition, retention, and improvement of skills related to activities of daily living, such as personal grooming, household chores, eating and food preparation, and other social adaptive skills necessary to enable the person to reside in the community. To accomplish these goals, the provider shall:

(a) Use observation, conversation, and other interactions as necessary to develop a functional analysis of the person's capabilities within the first month of the person's residency;
(b) Prepare a support plan with measurable outcomes using the functional analysis, the IHP or ISP and Plan of Care, and other information available to develop and maintain as appropriate the skills necessary to enable the person to reside in the community while maintaining his or her health and safety; and
(c) Report quarterly to the person, family, guardian, and DDS Case Manager the outcomes of the programming and support provided to help the person to achieve the identified outcomes.

946.6 Each provider of residential habilitation services shall ensure that each person receives hands-on support, habilitation, and other supports, when appropriate, which shall include, but not be limited to, the following areas:

(a) Eating and drinking;
(b) Toileting;
(c) Personal hygiene;
(d) Dressing;
(e) Grooming;
(f) Monitoring health and physical condition and assistance with medication or other medical needs;
(g) Communications;
(h) Interpersonal and social skills;
(i) Home management;
(j) Mobility;
(k) Time management;
(l) Financial management;
(m) Academic and pre-academic skills;
(n) Motor and perceptual skills;
(o) Problem-solving and decision-making;
(p) Human sexuality;
(q) Aesthetic appreciation; and

(r) Opportunity for social, recreational, and religious activities utilizing community resources.

946.7 Each provider of residential habilitation services shall ensure that each person receives the professional services required to meet his or her goals as identified in the person's IHP or ISP and Plan of Care. Professional services may include, but are not limited to, the following disciplines or services:

(a) Medicine;
(b) Dentistry;
(c) Education;
(d) Nutrition;
(e) Nursing;
(f) Occupational therapy;
(g) Physical therapy;
(h) Psychology;
(i) Social work;
(j) Speech, hearing, and language therapy; and
(k) Recreation.

946.8 Each provider of residential habilitation services shall ensure the provision of transportation services to enable persons to gain access to Waiver and other community services and activities. The provider shall comply with the requirements governing transportation services set forth in section 1903.5 of Title 29 DCMR if providing transportation services.

946.9 The minimum daily ratio of on-duty direct care staff to persons present in each GHMRP that serves persons who are not determined by DDS to have higher acuity shall not be less than the following:

(a) 1:6 during the waking hours of the day, approximately 6:00 a.m. to 2:00 p.m., when persons remain in the GHMRP during the day;
(b) 1:4 during the period of approximately 2:00 p.m. to 10:00 p.m.; and
(c) 1:6 during the sleeping hours of the night, approximately 10:00 p.m. to 6:00 a.m.

946.10 Each provider of residential habilitation services shall be a social services agency as described in section 1903.1 of Title 29 DCMR. In addition, the provider shall:

(a) Be a member of the resident's interdisciplinary team;
(b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for residential habilitation services under the Waiver;
(c) Maintain a copy of the most recent IHP or ISP and Plan of Care that has been approved by DDS for each person;

(d) Have a current Human Care Agreement with DDS for the provision of residential services;
(e) Ensure that all residential habilitation services staff are qualified and properly supervised to include having a plan to provide staff interpreters for non-English speaking persons;
(f) Ensure that the service provided is consistent with the person's IHP or ISP and Plan of Care;
(g) Offer the Hepatitis B vaccination to each person providing services pursuant to these rules;
(h) Provide staff training in infection control procedures consistent with the standards established by the Federal Centers for Disease Control and Prevention (CDC);
(i) Ensure compliance with DDS policies governing reporting of unusual incidents, human rights, behavior management, and protection of person's funds;
(j) Ensure that each residence is accessible to public transportation and emergency vehicles;
(k) Ensure that each group home is barrier-free if needed by the person;
(l) Maintain a written staffing plan;
(m) Provide a written staffing schedule for each site where services are provided;
(n) Comply with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238; D.C. Official Code § 44-551 *et seq.*);
(o) Ensure that each staff member has been screened for communicable disease, in accordance with the guidelines issued by the CDC; and
(p) Meet the DDS Basic Assurances set forth in the Human care Agreement.

946.11 Each person providing residential habilitation services for a provider under section 946.10 shall meet all of the requirements of section 1911 of Title 29 DCMR.

946.12 Each provider shall cooperate with DDS case management in providing access and information as requested for case management visits and reviews.

946.13 Each provider of residential habilitation services shall review the person's IHP or ISP and Plan of Care goals, objectives, and activities at least quarterly and more often, as necessary. The provider shall propose modifications to the IHP or ISP and Plan of Care, as appropriate. The results of these reviews shall be submitted to the DDS case manager within thirty (30) days of the end of each quarter. Each provider shall participate in IHP or ISP and Plan of Care development so that community integration goals are clearly defined. Each provider shall also assist in the coordination of all services that a person may receive.

946.14 Each provider of residential habilitation services shall maintain progress notes on a weekly basis, or more frequently if indicated, which include: progress in meeting each goal in the ISP; any unusual health or behavioral events or change in status; a recording of visitors and the person's participation in the visit; a listing of all community activities attended by the person and the response to those activities; and any matter requiring follow-up on the part of the service provider or DDS. Each provider shall also maintain participant attendance rosters on a daily basis and current financial records of expenditures of public and private funds for each person.

946.15 Each provider of residential habilitation services shall maintain all records and reports for at least six (6) years after the person's date of discharge.

946.16 Residential habilitation services shall not be reimbursed when provided by a member of the person's family.

946.17 Reimbursement for residential habilitation services shall not include:

(a) Cost of room and board;
(b) Cost of facility maintenance, upkeep, and improvement; and
(c) Activities for which payment is made by a source other than Medicaid.

946.18 The reimbursement rate for residential habilitation services is calculated based on the staff being awake while on duty and shall include:

(a) All supervision of direct support staff;
(b) All nursing provided in the residence for medication administration, physician ordered protocols and procedures, charting, other supports as per physician's orders, and maintenance of the Health Management Care Plan;
(c) Transportation to day programs, employment, professional appointments, community outings, and events;
(d) Programmatic supplies; and
(e) General and administrative fees for Waiver services.

946.19 The reimbursement rate for residential habilitation services for a GHMRP with four (4) individuals shall be as follows:

(a) The Basic Support Level 1 daily rate shall be two hundred seventeen dollars ($217.00) for a direct care staff support ratio of 1:4 for all awake and overnight hours;
(b) The Moderate Support Level 2 daily rate shall be three hundred forty-four dollars ($344.00) for a direct care staff support ratio of 1:4 for awake overnight and 2:4 during all awake hours when individuals are in the home and adjusted for increased absenteeism;

(c) The Enhanced Moderate Support Level 3 daily rate shall be four hundred eighty-four dollars ($484.00) for a direct care staff support ratio of 2:4 for awake overnight and 2:4 during all awake hours when individuals are in the home and adjusted for increased absenteeism.

(d) The Intensive Support daily rate shall be five hundred sixty-one dollars ($561.00) for a direct care staff support ratio of 2:4 for awake overnight and 3:4 during all awake hours when individuals are in the home and adjusted for increased absenteeism.

946.20 The reimbursement rate for residential habilitation services for a GHMRP with five (5) to six (6) individuals shall be as follows:

(a) The Basic Support Level 1 daily rate shall be two hundred seventy-two dollars ($272.00) for a direct care staff support ratio of 1:5/6 for awake overnight and 2:5/6 during all awake hours when individuals are in the home.

(b) The Moderate Support Level 2 daily rate shall be three hundred sixty-seven dollars ($367.00) for a direct care staff support ratio of 2:5/6 for awake overnight and 2:5/6 during all awake hours when individuals are in the home and adjusted for increased absenteeism

(c) The Enhanced Moderate Support Level 3 daily rate shall be four hundred forty-four dollars ($444.00) for a staff support ratio of 2:5/6 for awake overnight and 3:5/6 during all awake hours when individuals are in the home and adjusted for increased absenteeism.

(d) The Intensive Support daily rate is five hundred fifty-five dollars ($551.00) for increased direct care staff support for sleep hours to 2:5/6 for awake overnight support and 4:5/6 during all awake hours when individuals are in the home and adjusted for increased absenteeism.

946.21 Acuity evaluation to set support levels shall be determined by a committee appointed by the Director of DDS that shall review current staffing levels, available health and behavioral records, and any available standardized acuity instrument results to determine if a person has a health or behavioral acuity that requires increased supports. Individuals may be assessed at a support level that is consistent with their current staffing level if other acuity indicators are not in place.

946.22 Residential habilitation services shall not be billed concurrently with the following Waiver services:

(a) Environmental accessibility adaptation;
(b) Vehicle modifications;
(c) Supported living;
(d) Respite;
(e) Host home;

(f) Live-in caregiver;
(g) In-Home supports;
(h) Personal Emergency Response System; or
(i) Transportation.

946.23 Residential habilitation services shall not be billed when the person is hospitalized, on vacation, or for any other period in which the person is not residing at the GHMRP.

946.24 Direct care staff shall be dressed, alert, and maintain support logs during the entire shift of awake hours.

946.99 DEFINITIONS

When used in this section, the following terms and phrases shall have the meanings ascribed:

Awake – For purposes of staffing and determining the reimbursement rates for residential habilitation services, awake hours of the day, with absence from day program, weekend, or holiday, shall be approximately 6:00 a.m. to 10:00 p.m., and for purposes of awake hours for all other days shall be approximately 6:00 a.m. to 10:00 a.m. and 2:00 p.m. to 10:00 p.m.

Communicable Disease – Shall have the same meaning as set forth in section 201 of Title 22 DCMR.

Community Integration – Participation in events outside of the person's place of residence that may include shopping, dining, attending movies, plays, and other social events. The plan from section 946.13 should identify community and social events appropriate for the person.

Direct Care Staff – Individuals employed to work in the GHMRP who render the day-to-day, personal assistance that a person requires in order to meet the goals of his or her IHP or ISP and Plan of Care.

Family – Any person who is related to the person receiving services by blood, marriage, or adoption.

Group Home for Mentally Retarded Persons (GHMRP) – A community residence facility, other than an intermediate care facility for persons with mental retardation, that provides a homelike environment for at least four (4) but no more than six (6) related or unrelated persons with intellectual disabilities who require specialized living arrangements and maintains necessary staff, programs, support services, and equipment for their care and habilitation.

Health Management Care Plan – A written document designed to evaluate an individual's health care status and to provide recommendations regarding the treatment and amelioration of health care issues by identifying types of risks, interventions to manage identified risks, individuals responsible for carrying out interventions, and individuals responsible for providing evaluation of outcomes and timeframes.

Individual – Individual participant enrolled in the Waiver receiving services.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1304.03).

Individual Support Plan (ISP) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Interdisciplinary Team – A group of persons with special training and experience in the diagnosis and habilitation of mentally retarded persons and who have the responsibility of performing a comprehensive evaluation of a person while participating in the development, implementation, and monitoring of the person's IHP or ISP and Plan of Care.

Overnight – For purposes of staffing and determining the reimbursement rates for residential habilitation services, the overnight period shall be approximately from 10:00 p.m. to 6:00 a.m.

Person/ Participant– An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Waiver.

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to pre-authorize Waiver services.

Progress Notes – Notes that observe (1) progress in meeting each goal in the IHP or ISP and Plan of Care, which is the responsibility of the residence; (2) the list of community activities for the week and the participant's response to each activity; (3) any unusual health events; (4) any visitors the participant received; and (5) anything requiring follow-up or action.

Provider – Any non-profit, home health agency, social service agency, or other business entity that provides services pursuant to these rules.

Waiver – The Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human

Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, DC 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02) (2006 Rpl.), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption, on an emergency basis, of an amendment to section 993 of Chapter 9 of Title 29 (Public Welfare) of the District of Columbia Municipal Regulations (DCMR), entitled "Independent Habilitation Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for independent habilitation services, which is renamed Supported Living Services, and is provided by qualified professionals to participants with mental retardation and developmental disabilities in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

This rulemaking amends the rules entitled "Independent Habilitation Services" previously published at 54 DCR 6435 (June 29, 2007), by changing the name to Supported Living Services and providing a blend of the previously-available services under the former Waiver (*i.e.* Homemaker Services, Chore Services , Adult Companion Services, Personal Care Services, Attendant Care Services, and Independent Habilitation Services) that will be delivered under the modified Waiver effective November 20, 2007 based on a plan developed by the person and his/her support team. This service delivery approach will address the problems encountered when multiple provider agencies and support staff were needed to deliver supports in a person's home due to the different provider qualifications and restrictions for each service. The new rules are intended to resolve the staffing issues which have made it difficult to effectively support individuals in smaller unlicensed settings. Supported living services is a twenty-four (24) hour service limited to residences owned, leased or otherwise operated by the provider with three (3) or fewer residents. The reimbursement rates have been modified based on a new rate setting methodology and the collapsing of services into daily rates based on acuity. An acuity system has been implemented to address the varying support needs of the persons being served. The acuity system is based on the intensity of staffing required for each unique residence. This service may also be delivered as an hourly drop in service for person's who do not require paid and/or unpaid twenty-four (24) hour residential support.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of supported living services. These emergency rules are needed so that, on the effective date of the Waiver as modified, there will be rules in place consistent with the provisions of the Waiver as modified to provide supported living services in smaller unlicensed residences based on a daily rate that are in turn based on the acuity level of the persons being served.

The District of Columbia Medicaid Program is also modifying the Waiver to reflect these changes. The Council of the District of Columbia has approved the corresponding Waiver. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services have also approved the Waiver with an effective date of November 20, 2007. The emergency rulemaking was adopted on November 19, 1997, and will become effective on November 20, 2007. The emergency rules will remain in effect for 120 days or until March 18, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Section 993 (Independent Habilitation Services) of Chapter 9 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

993 SUPPORTED LIVING SERVICES

993.1 Supported living services shall be reimbursed by the District of Columbia Medicaid Program for each participant in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

993.2 In order to qualify for reimbursement under this section, supported living services shall be delivered in a Supported Living Residence (SLR) that can serve one (1) to three (3) persons and the number of persons in the home shall not exceed the number of bedrooms in that home. The SLR must be owned, leased or otherwise operated by the Supported Living Provider. The SLR shall meet the certification standards developed by the Department on Disability Services (DDS) as set forth in the Human Care Agreement between DDS and the SLR or be licensed or similarly certified in other states.

993.3 Each home located out-of-state shall be licensed or certified in accordance with the host state's laws and regulations and consistent with the terms and conditions set forth in an agreement between the District of Columbia and the host state. Each out-of-state provider shall comply with the following additional requirements:

(a) Remain in good standing in the jurisdiction where the program is located;
(b) Submit a copy of the annual certification or survey performed by the host state and provider's corrective action, if applicable, to DDS; and
(c) Allow authorized agents of the District of Columbia government, federal government, and governmental officials of the host state full access to all sites and records for audits and other reviews.

993.4 Supported living services shall be available only to a person with a demonstrated need for training, assistance and supervision, and shall be authorized and provided in accordance with the person's current Individual Habilitation Plan (IHP) or Individual Support Plan (ISP) and Plan of Care.

993.5 Each provider of supported living services shall assist participants in the acquisition, retention, and improvement of skills related to activities of daily living, such as personal grooming, household chores, eating and food preparation, and other social and adaptive skills necessary to enable the person to reside in the community. To accomplish these goals, the provider shall:

(a) Use observation, conversation, and other interactions as necessary to develop a functional analysis of the person's capabilities within the person's first month of service;
(b) Prepare a support plan with measurable outcomes using the functional analysis, the IHP or ISP and Plan of Care, and other information available to develop and maintain as appropriate the skills necessary to enable the person to reside in the community while maintaining the person's health and safety; and
(c) Prepare a data-based quarterly report for distribution to the person, family, guardian, and DDS Case Manager on the activities and support provided to help the person to achieve his/her identified outcomes and his/her progress to date.

993.6 Each provider of supported living services shall ensure that participants receive hands-on support, habilitation, and other supports, when appropriate, which shall include, but not be limited to, the following areas:

(a) Eating and drinking;
(b) Toileting;
(c) Personal hygiene;
(d) Dressing;
(e) Grooming;
(f) Monitoring health and physical condition and assistance with medication or other medical needs;
(g) Communication;
(h) Interpersonal and social skills;
(i) Home management;
(j) Mobility;
(k) Time management;
(l) Financial management;
(m) Academic and pre-academic skills, other than those prescribed by the Individuals with Disabilities in Education Act;
(n) Motor and perceptual skills;
(o) Problem-solving and decision-making;
(p) Human sexuality;

(q) Aesthetic appreciation; and
(r) Opportunity for social, recreational, and religious activities utilizing community resources.

993.7 Each provider of supported living services shall ensure that each participant receives the professional/medical services required to meet his or her goals as identified in the person's IHP or ISP and Plan of Care, through the support of the SLR provider to coordinate and ensure receipt of the professional/medical services. Professional/medical services may include, but are not limited to, the following disciplines or services:

(a) Medicine;
(b) Dentistry;
(c) Education;
(d) Nutrition;
(e) Nursing;
(f) Occupational therapy;
(g) Physical therapy;
(h) Psychology;
(i) Social work;
(j) Speech, hearing and language therapy; and
(k) Recreation.

993.8 Each provider of supported living services shall provide or ensure the provision of transportation services to enable the persons to gain access to Waiver and other community services and activities. If transportation services are provided by the SLR, the provider shall meet the requirements governing transportation services set forth in section 1903 of Title 29 DCMR.

993.9 Each provider of supported living services shall be a social services agency as described in Chapter 9 of Title 29 of the District of Columbia Municipal Regulations (DCMR), Section 1903.1. In addition, the provider shall:

(a) Be a member of the person's interdisciplinary team;
(b) Have a current District of Columbia Medicaid Provider Agreement that authorizes the provider to bill for Supported Living Services under the Waiver;
(c) Maintain a copy of the most recent IHP or ISP and Plan of Care that has been approved by DDS for each person;
(d) Have a current Human Care Agreement with DDS for the provision of residential services;
(e) Ensure that all supported living services staff are qualified and properly supervised pursuant to all applicable rules;
(f) Ensure that all providers have a plan to provide staff interpreters for non-English speaking persons;
(g) Ensure that the service provided is consistent with the person's IHP or ISP and Plan of Care;

(h) Offer the Hepatitis B vaccination to each person providing services pursuant to these rules;
(i) Provide staff training in infection control procedures consistent with the standards established by the Federal Centers for Disease Control and Prevention;
(j) Ensure compliance with DDS policies governing reporting of unusual incidents, human rights, behavior management, and protection of person's funds;
(k) Ensure that each SLR, to the extent necessary, is accessible to public transportation and emergency vehicles;
(l) Ensure that each SLR, to the extent necessary, is handicapped accessible and barrier-free;
(m) Provide a written staffing schedule for each location where services are provided; and
(n) Comply with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code § 44-551 *et seq.*).

993.10 Each person providing supported living services for a person shall meet all of the requirements in Chapter 19 to Title 29 DCMR, section 1911 in addition to the requirements set forth below:

(a) Complete competency based training in emergency procedures; and
(b) Be certified annually in cardiopulmonary resuscitation and First Aid.

993.11 Each provider shall cooperate with the DDS case management in providing access and information as requested for case management visits and reviews.

993.12 Each provider of supported living services shall review the person's IHP or ISP and Plan of Care goals, objectives, and activities at least quarterly and more often, as necessary. The provider shall propose modifications to the IHP or ISP and Plan of Care, as appropriate. The results of these reviews shall be submitted to the case manager within thirty (30) days of the end of each quarter. Each provider shall participate in IHP or ISP and Plan of Care development so that community integration goals are clearly defined. Each provider shall also assist in the coordination of all services that a person may receive.

993.13 Each provider of supported living services shall maintain progress notes on a weekly basis, or more frequently if indicated, on the IHP or ISP and Plan of Care, participant attendance rosters on a daily basis, and maintain current financial records of expenditures of public and private funds for each person. The progress notes shall include at a minimum notations which demonstrate:

(a) Progress in meeting each goal in the ISP assigned to the supported living services provider;
(b) A list of all community activities the person participates in and the person's response to each activity;
(c) Any unusual health events, side effects to medication, change in health status, behavioral event, use of a restrictive procedure or unusual incident; and
(d) Each visitor the person receives, special events, and any situation or event requiring follow-up.

993.14 Each provider of supported living services shall maintain all records and reports for at least six (6) years after the person's date of discharge.

993.15 Supported living services shall not be reimbursed when provided by a member of the person's family.

993.16 Reimbursement for supported living services under the Waiver shall not include:

(a) Cost of room and board;
(b) Cost of facility maintenance, upkeep and improvement, modifications or adaptations to a home to meet the requirements of the applicable life safety code; or
(c) Activities for which payment is made by a source other than Medicaid.

993.17 The reimbursement rate for supported living services shall include:

(a) All direct support staff and supervision of support staff;
(b) All nursing provided in the residence for medication administration, physician ordered protocols and procedures, charting, other supports as per physician's orders, and maintenance of Health Management Care Plan;
(c) Programmatic supplies and indirect expenses; and,
(d) General and administrative fees for waiver services.

993.18 The reimbursement rate for supported living services shall be as follows:

(a) The Basic Support Level 1 staff asleep overnight daily rate for a SLR with three (3) residents the rate shall be one hundred and ninety-five ($195.00) for a direct care staff support ratio of 1:3 during all hours when residents are in the home;
(b) The Basic Support Level 2 staff awake overnight daily rate for a SLR with three (3) residents shall be two hundred forty dollars ($240.00) for a direct care staff support ratio of 1:3 for staff awake overnight and 1:3 during all awake hours when residents are in the home;

(c) The Moderate Support Level 1 staff asleep overnight daily rate for a SLR with three (3) residents shall be two hundred eighty-six dollars ($286.00) for a direct care staff support ratio of 2:3 for eight (8) hours a day, 1:3 during the remaining awake hours, and 1:3 staff asleep overnight coverage when residents are in the home;

(d) The Moderate Support Level 2 staff awake overnight daily rate for a SLR with three (3) residents shall be three hundred thirty dollars ($330.00) for a direct care staff support ratio of 2:3 for eight (8) hours a day, 1:3 during remaining awake hours, and 1:3 staff awake coverage when residents are in the home;

(e) The Intensive Support Level 1 daily rate for a SLR with three (3) residents shall be three hundred fifty-nine dollars ($359.00) for a direct care staff support ratio of 1:3 for staff awake overnight and 2:3 during all awake hours when residents are in the home and adjusted for increased absenteeism;

(f) The Intensive Support Level 2 daily rate for a SLR with three (3) residents shall be four hundred fifty dollars ($450.00) for a direct care staff support ratio of 2:3 for staff awake overnight and 2:3 during all awake hours when residents are in the home and adjusted for increased absenteeism;

(g) The Basic Support Level 1 staff asleep overnight daily rate for a SLR with two (2) residents shall be two hundred sixty-two dollars ($262.00) for a direct care staff support ratio of 1:2 staff asleep overnight coverage and 1:2 staff awake coverage during all hours when residents are in the home;

(h) The Basic Support Level 2 staff awake overnight daily rate for a SLR with two (2) residents shall be three hundred twenty-two dollars ($322.00) for a direct care staff support ratio of 1:2 for staff awake overnight and 1:2 during all awake hours when residents are in the home;

(i) The Moderate Support Level 1staff awake overnight daily rate for a SLR with two (2) residents shall be three hundred eighty-three dollars ($383.00) for a direct care staff support ratio of 2:2 for four (4) hours a day, 1:2 during remaining awake hours and 1:2 staff awake coverage when residents are in the home;

(j) The Moderate Support Level 2 daily rate in a SLR with two (2) residents shall be four hundred forty-four dollars ($444.00) for a direct care staff support ratio of 1:2 for staff awake overnight and 2:2 for eight (8) hours a day, 1:2 during remaining awake hours when residents are in the home and adjusted for increased absenteeism;

(k) The Intensive Support Level 3 daily rate in a SLR with two (2) residents shall be four hundred eighty-two dollars ($482.00) for a direct care staff support ratio of 1:2 for staff awake overnight and 2:2 for all awake hours when residents are in the home and adjusted for increased absenteeism; and

(l) The hourly rate for periodic supported living services shall be twenty-two dollars ($22.00) per hour billable in quarter hour units of five dollars and fifty cents ($5.50) per unit.

993.19 Individualized twenty-four (24) hour supervision shall only be permitted with prior authorization of the DDS Human Rights Committee and shall be reimbursed at the daily rate of four hundred and three dollars ($403.00) for 1:1 services with asleep overnight staff and four hundred and ninety-five dollars ($495.00) a day for 1:1 services with awake overnight staff. This shall be adjusted if more than one (1) person lives in the home depending upon the needs of the other persons who share the home. To be eligible for reimbursement for supported living one-to-one services, the person shall be required to have a behavior support plan and meet at least one of the characteristics set out in section 979.12 for paraprofessional one-to-one services or at least one of the characteristics set out in section 979.13 for professional one-to-one services. For purpose of this section 993.19, in addition to the requirements for paraprofessional one-to-one services and professional one-to-one services as set out in section 979.99, supported living one-to-one services means services provided to one person exclusively by a supported living services provider who has been trained in all general requirements and possesses all training required to implement the person's specific behavioral and/or clinical protocols and support plans for a pre-authorized length of time.

993.20 Acuity shall be determined by a committee appointed by the Director of DDS that shall review current staffing levels, available health and behavioral records, and any available standardized acuity instrument results to determine if a person has a health or behavioral acuity that requires increased supports. Participants shall be designated with a support level that is consistent with their current staffing level if other acuity indicators are not yet in place.

993.21 Long-term twenty-four (24) hour paid support single-person placements in a SLR are only permitted for a person having a history of challenging behaviors that may put others at risk and requires intensive supports as determined by a psychological assessment or pursuant to a court. The psychological assessment shall be updated on an annual basis to determine the continued necessity for this single 24 hour placement.

993.22 Each provider of supported living services shall coordinate the delivery of necessary behavioral support services, and skilled nursing services from approved Waiver providers of those services based on the requirements of the IHP or ISP and Plan of Care.

993.23 Supported living services shall not be billed concurrently with the following Waiver services:

(a) Residential Habilitation;
(b) Respite;
(c) Host Home;
(d) Live-in Caregiver; and
(e) In-Home Supports.

993.24 Supported living services shall not be billed when the person is hospitalized, on vacation, or for any other period in which the person is not residing at the SLR. The reimbursement rates assume a 93% annual occupancy, and unanticipated absence from day/vocational services or employment due to illness, and planned absence for holidays.

993.25 Direct care staff shall be dressed, alert and maintain support logs during the entire shift of awake hours.

993.99 DEFINITIONS

When used in this section, the following terms and phrases shall have the meanings ascribed:

Awake – For purposes of staffing and the reimbursement rates for supported living services, awake hours of the day with absence from day program, weekend, or holiday shall be approximately 6:00 a.m. to 10:00 p.m., and for purposes of awake hours for all other days shall be approximately 6:00 am to 10:00 a.m. and 2:00 p.m. to 10:00 p.m.

Community Integration – Participation in events outside of the person's place of residence that may include shopping, dining, attending movies, plays, and other social events. The plan from section 993.12 should identify community and social events appropriate for the person.

Direct Care Staff – individuals employed to work in a SLR who render the day-to-day, personal assistance that person requires in order to meet the goals of his or her IHP or ISP and Plan of Care.

Family – Any person who is related to the person receiving services by blood, marriage or adoption.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1304.03).

Individual Support Plan (ISP) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Interdisciplinary Team – a group of persons with special training and experience in the diagnosis and habilitation of mentally retarded persons who have the responsibility of performing a comprehensive person evaluation while participating in the development, implementation, and monitoring of the person's IHP or ISP and Plan of Care.

Overnight – For purposes of staffing and the reimbursement rates for supported living services, the overnight period shall be approximately from 10:00 p.m. to 6:00 a.m.

Person or Participant – An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver).

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Progress Notes – notes that observe (1) progress in meeting each goal in the IHP or ISP and Plan of Care, which is the responsibility of the residence; (2) the list of community activities for the week and the participant's response to each activity; (3) any unusual health events; (4) any visitors the participant received; and (5) anything requiring follow-up or action.

Provider – Any non-profit, home health agency, social service agency or other business entity that provides services pursuant to these rules.

Supported Living Residence (SLR) - a community residence or home, other than an intermediate care facility for persons with mental retardation, which provides a homelike environment for not more than three (3) related or unrelated persons who require specialized living arrangements and maintains necessary staff, programs, support services, and equipment for their care and habilitation.

Waiver – Shall mean the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, DC 20002, within thirty (30) days from the date

of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 744; D.C. Official Code § 1-307.02), Reorganization. Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption, on an emergency basis, of an amendment to Sections 1900 (General Provisions), 1901 (Covered Services), 1903 (Provider Qualifications), and 1999 (Definitions), and of a new Section 1911 (Requirements for Persons Providing Direct Services), of Chapter 19 to Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Home and Community-Based Waiver Services for Persons with Mental Retardation and Developmental Disabilities."

This rulemaking amend sections 1900 (General Provisions), 1901 (Covered Services), 1903 (Provider Qualifications), and 1999 (Definitions) of the rules previously published at 51 DCR 10207 (November 5, 2004), in connection with the approval by the District of Columbia Council and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), effective November 20, 2007, of the new District of Columbia Medicaid Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver). These four sections identify the Waiver as approved by the CMS, specify the twenty-five (25) Waiver services that are available to participants, set forth provider qualifications, and provide updated definitions. In addition, this rulemaking amends Chapter 19 by including a new section 1911 to set forth minimum standards for persons providing direct services to Waiver participants.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of Waiver services. These emergency rules are needed so that, on the effective date of the Waiver as modified and approved by CMS, the approved Waiver and covered services are identified and rules are in place consistent with the provisions of the approved Waiver

The emergency rulemaking was adopted on November 19, 2007, and became effective on November 20, 2007. The emergency rules will remain in effect for 120 days or until March 18, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Section 1900 (General Provisions) of Chapter 19 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

1900 GENERAL PROVISIONS

1900.1 The purpose of this chapter is to establish criteria governing Medicaid eligibility for services under the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) and to establish conditions of participation for providers of Waiver services.

1900.2 The Waiver is authorized pursuant to section 1915 (c) of the Social Security Act, approved by the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services (CMS), and shall be effective through November 19, 2012, plus any extensions thereof.

1900.3 The Waiver shall be operated by the Department on Disability Services (DDS), Developmental Disabilities Administration (DDA), under the supervision of the Department of Health, Medical Assistance Administration (MAA).

1900.4 Enrollment of persons eligible to receive Waiver services shall not exceed the ceiling established by the approved Waiver application.

Section 1901 (Covered Services) of Chapter 19 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

1901 COVERED SERVICES

1901.1 Services available under the Waiver shall include the following:

(a) Behavioral Supports, as set forth in section 937 of Title 29 DCMR;
(b) Community Support Team, as set forth in section 1912 of Title 29 DCMR;
(c) Day Habilitation, as set forth in section 945 of Title 29 DCMR;
(d) Dental, as set forth in section 936 of Title 29 DCMR;
(e) Environmental Accessibilities Adaptations, as set forth in section 926 of Title 29 DCMR;
(f) Family Training, as set forth in section 942 of Title 29 DCMR;
(g) Host Home, as set forth in section 1915 of Title 29 DCMR;
(h) In-Home Supports, as set forth in section 1916 of Title 29 DCMR;
(i) Live-in Caregiver, as set forth in section 1917 of Title 29 DCMR;
(j) Nutrition Evaluation and Consultation, as set forth in section 930 of Title 29 DCMR;
(k) Occupational Therapy, as set forth in section 935 of Title 29 DCMR;
(l) One-time Transitional, as set forth in section 1913 of Title 29 DCMR;

(m) Personal Care Services as an extended service under the State Plan for Medical Assistance as set forth in sections 5004 and 1910 of Title 29 DCMR;
(n) Personal Emergency Response System (PERS), as set forth in section 907 of Title 29 DCMR;
(o) Physical Therapy, as set forth in section 934 of Title 29 DCMR;
(p) Prevocational, as set forth in section 920 of Title 29 DCMR;
(q) Professional Services, as set forth in section 1918 of Title 29 DCMR
(r) Residential Habilitation, as set forth in section 946 of Title 29 DCMR,
(s) Respite, as set forth in section 994 of Title 29 DCMR;
(t) Skilled Nursing, as an extended service under the State Plan for Medical Assistance and as set forth in section 933 of Title 29 DCMR;
(u) Speech, Hearing and Language, as set forth in section 932 of Title 29 DCMR;
(v) Supported Employment, as set forth in section 929 of Title 29 DCMR;
(w) Supported Living, as set forth in section 993 of Title 29 DCMR;
(x) Transportation, as set forth in section 943 of Title 29 DCMR; and
(y) Vehicle Modifications, as set forth in section 1914 of Title 29 DCMR.

Section 1903 (Provider Qualifications) of Chapter 19 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

1903 PROVIDER QUALIFICATIONS

1903.1 Social Service Agency or Sole Proprietor Agency applicants shall complete an application to participate in the Medicaid Waiver program and shall submit to DDS both the application and following organizational information:

(a) A description of ownership and a list of major owners or stockholders owning or controlling five (5) percent or more outstanding shares;
(b) A list of Board members and their affiliations;
(c) A roster of key personnel, with qualifications, resumes, and a copy of their position descriptions;
(d) A copy of the most recent audited financial statement of the organization;
(e) A completed copy of the waiver provider application;
(f) A copy of the basic organizational documents of the provider, including an organizational chart, and current Articles of Incorporation or partnership agreement, if applicable;
(g) A copy of the Bylaws or similar documents regarding conduct of the provider's internal affairs;
(h) A copy of the business license and or certificate of good standing;
(i) A copy of professional/business liability insurance of at least one (1) million dollars;

(j) Organizational policies and procedures, such as personnel policies and procedures, human rights, incident reporting, behavioral support policies, staff training, protection of consumer funds, and others as required by DDS;
(k) A continuous quality improvement plan; and
(l) Any other documentation deemed necessary to support the approval as a provider.

1903.2 Professional service provider applicants who are in private practice as an independent practitioner shall complete an application to participate in the Medicaid Waiver program and shall agree to:

(a) Maintain a private office, even if services are always furnished in the home of the person receiving services;
(b) Meet all state and local licensure laws and rules;
(c) Maintain at least one (1) million dollars in liability insurance;
(d) Ensure that services provided are consistent with the individual habilitation plan (IHP) or individual service plan (ISP) and Plan of Care;
(e) Ensure that, if services are furnished in a private practice office space, that space shall be owned, leased, or rented by the private practice and shall be used for the exclusive purpose of operating the private practice; and
(f) Personally supervise assistants and aides employed directly by the independent practitioner, by the partnership group to which the independent practitioner belongs, or by the same private practice that employs the independent practitioner. Personal supervision requires the independent practitioner to be in the room during the performance of the service.

1903.3 Home Health Agency or Skilled Nursing Service provider applicants shall complete an application to participate in the Medicaid Waiver program and shall meet the definitions and licensure requirements to participate as a Home Health Agency or Skilled Nursing Service as follows:

(a) Home Health Agency – Shall have the same meaning as "home care agency" and shall meet the definitions and licensure requirements as set forth in the Health-Care and Community Residence Facility, Hospice and Home Care Licensure Act of 1983, effective February 24, 1984 (D.C. Law 5-48; D.C. Official Code § 44-501 *et seq.*), and implementing rules; and
(b) Skilled Nursing Service – Health care services that are delivered by a registered or practical nurse acting within the scope of their practice and shall meet the definitions and licensure requirements as set forth in the District of Columbia Health Occupations Revision Act of 1985,

effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201 *et seq.*), and implementing rules.

1903.4 Each service provider under the Waiver for which transportation is included in the Waiver service shall:

(a) Ensure that each vehicle used to transport an individual has valid license plates;
(b) Ensure that each vehicle used to transport an individual has at least the minimum level of motor vehicle insurance required by law;
(c) Present each vehicle used to transport an individual for inspection by a certified inspection station every six months (or as required in the jurisdiction where the vehicle is registered) and provide proof that the vehicle has passed the inspection by submitting a copy of the Certificate of Inspections to DDS upon request;
(d) Ensure that each vehicle used to transport an individual is maintained in safe, working order,
(e) Ensure that each vehicle used to transport an individual meets the needs of the individual;
(f) Ensure that each vehicle used to transport an individual has seats fastened to the body of the vehicle;
(g) Ensure that each vehicle used to transport an individual has operational seat belts;
(h) Ensure that each vehicle used to transport an individual has temperature conducive to comfort;
(i) Ensure that each vehicle used to transport an individual is certified by the Washington Metropolitan Area Transit Commission;
(j) Ensure that each individual is properly seated when the vehicle is in operation;
(k) Ensure that each individual is transported to and from each appointment in a timely manner;
(l) Ensure that each individual is provided with an escort on the vehicle, when needed;
(m) Ensure that each vehicle used to transport a person with mobility needs is adapted to provide safe access and use;
(n) Ensure that each person providing services meet the requirements set forth in section 1911 of these rules; and
(o) Ensure that each person providing services be certified in cardiopulmonary resuscitation and First Aid.

1903.5 MAA shall notify each prospective provider, in writing, of the approval or disapproval to become a provider of Waiver services, no later than fifteen (15) days of receipt of all required documentation. If additional information is requested by MAA, the provider shall have thirty (30) days from the date of the request to submit the additional information. If an application is disapproved, the notice shall set forth the reason for disapproval. Failure to submit all required documentation may result in disapproval.

1903.6 Each provider shall enter into a provider agreement with MAA for the provision of Waiver services.

1903.7 The provider agreement shall specify the services to be provided, methods of operation, financial and legal requirements, and identification of the population to be served.

1903.8 Each provider shall be subject to the administrative procedures set forth in Chapter 13 of Title 29 DCMR, to the provider certification standards established by DDS (currently known as the Basic Assurance Standards Authorization process), and to all policies and procedures promulgated by DDS that are applicable to providers during the provider's participation in the Waiver program.

1903.9 Each provider shall comply with all applicable provisions of District and federal law and rules applicable to the Title XIX of the Social Security Act, and all District and federal law and rules applicable to the service or activity provided pursuant to these rules.

A new Section 1911 (Requirements for Persons Providing Direct Services) of Chapter 19 of Title 29 DCMR is adopted to read as follows:

1911 REQUIREMENTS FOR PERSONS PROVIDING DIRECT SERVICES

1911.1 The basic requirements for all employees providing direct services are as follows:

(a) Be at least eighteen (18) years of age;
(b) Be acceptable to the person to whom services are provided;
(c) Demonstrate annually that he or she is free from communicable disease as confirmed by an annual PPD Skin Test or documentation from a physician;
(d) Possess a high school diploma or general educational development (GED) certificate;
(e) Complete pre-service and in-service training as required by DDS;
(f) Have the ability to communicate with the person to whom services are provided;
(g) Be able to read, write, and speak the English language; and
(h) Comply with the requirements of the Health-Care Facility Unlicensed Personnel Criminal Background Check Act of 1998, effective April 20, 1999 (D.C. Law 12-238), as amended by the Health-Care Facility Unlicensed Personnel Criminal Background Check Amendment Act of 2002, effective April 13, 2002 (D.C. Law 14-98; D.C. Official Code § 44-551 *et seq.*).

Section 1999 (Definitions) of Chapter 19 of Title 29 DCMR is deleted in its entirety and amended to read as follows:

1999 DEFINITIONS

When used in this Chapter, the following terms and phrases shall have the meanings ascribed:

Client – An individual who has been determined eligible to receive services under the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1304.03).

Individual Support Plan (ISP) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Intermediate Care Facility for Persons with Mental Retardation – Shall have the same meaning as set forth in section 1905(d) of the Social Security Act.

Mentally retarded – Shall have the same meaning as set forth in D.C. Official Code § 7-1301.03(19).

Quality Assurance Plan – A written plan that describes the process by which the provider shall evaluate the quality and appropriateness of services delivered to each individual. The plan should describe the process and frequency of implementation for identifying, evaluating and resolving any problem related to the services rendered.

Qualified mental retardation professional – Shall have the same meaning as set forth in 42 CFR § 483.430(a).

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Person or Participant – An individual who has been determined eligible to receive services under the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities.

Person's home – Shall mean the natural home, but shall not include an institutional or residential facility or foster home.

Provider – Any entity that meets the Waiver service requirements, has signed an agreement with MAA to provide those services, and is enrolled by MAA to provide Waiver services.

Registered Nurse – A person who is licensed or authorized to practice registered nursing pursuant to the District of Columbia Health Occupations Revisions Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1202 *et seq.*) or licensed as a registered nurse in the jurisdiction where services are provided.

Waiver – Shall mean the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, D.C. 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DEPARTMENT OF HEALTH

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the Department of Health, pursuant to the authority set forth in An Act to enable the District of Columbia to receive Federal financial assistance under Title XIX of the Social Security Act for a medical assistance program, and for other purposes, approved December 27, 1967 (81 Stat. 774; D.C. Official Code § 1-307.02), Reorganization Plan No. 4 of 1996, and Mayor's Order 97-42, dated February 18, 1997, hereby gives notice of the adoption, on an emergency basis, of a new section 1912 of Chapter 19 of Title 29 of the District of Columbia Municipal Regulations (DCMR), entitled "Community Support Team Services." These rules establish standards governing reimbursement by the District of Columbia Medicaid Program for preventive, consultative and crisis support services provided by health care professionals to participants with dual diagnosis of mental retardation and mental illness in the Home and Community-based Services Waiver for persons with Mental Retardation and Developmental Disabilities (Waiver).

The former Preventive, Consultative and Crisis Support Services rules in Section 937 of Chapter 29 DCMR incorporate two discrete services into a single rule: preventive and consultative services, which focus on long-term behavioral support, and crisis services, which focuses on short-term response to an immediate crisis. This rule adopts a new rule focusing on the crisis portion of the former rule and changes the name of the service to Community Support Team Services.

Emergency action is necessary for the immediate preservation of the health, safety, and welfare of Waiver participants who are in need of community support team services. These emergency rules are needed so that, on the effective date of the Waiver as modified, there will be rules in place consistent with the provisions of the Waiver as modified to focus on crisis services and change the name of the services to Community Support Team Services.

The District of Columbia Medicaid Program also is modifying the Waiver to reflect these changes. The Council of the District of Columbia has approved the corresponding Waiver. The U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services have also approved the corresponding Waiver with an effective date of November 20, 2007. The emergency rulemaking was adopted on November 19, 2007, and will become effective on November 20, 2007. The emergency rules will remain in effect for one hundred and twenty (120) days or until March 18, 2008, unless superseded by publication of a Notice of Final Rulemaking in the *D.C. Register*, whichever comes first.

The Director also gives notice of the intent to take final rulemaking action to adopt these proposed rules not less than thirty (30) days from the date of publication of this notice in the *D.C. Register*.

Section 1912 (Community Support Team Services) of Chapter 19 of Title 29 DCMR is adopted to reads as follows:

1912 COMMUNITY SUPPORT TEAM SERVICES

1912.1 Community support team (CST) services shall be reimbursed by the District of Columbia Medicaid Program for each participant in the Home and Community-based Services Waiver for Persons with Mental Retardation and Developmental Disabilities (Waiver) subject to the requirements set forth in this section.

1912.2 To be eligible for CST services, the following criteria shall be identified during each participant's Diagnostic Assessment:

(a) An ongoing pattern of behavior that includes physical harm to self or others and /or behaviors/psychiatric symptoms which have led to institutionalization in the past or have a high probability of resulting in institutionalization (*e.g.*, self-injurious behavior, physical aggression, illegal or inappropriate sexual acts, reckless endangerment, psychiatric conditions leading to the denial of self-preservation or extremely poor hygiene);

(b) An imminent risk of institutionalization; or

(c) A need for twenty-four (24) hour supports and crisis planning to support health and safety.

1912.3 CST services shall not include onsite crisis intervention services and is not designed to adequately serve people who threaten or attempt suicide or homicide or who have a pattern of felony violations involving violence or the victimization of others.

1912.4 CST services are designed to support and encourage the participant in his or her decision to reside within the community; decrease the impact of a behavioral and/or psychiatric event; assist the participant in developing alternative and more effective communication skills, adaptive and coping mechanisms; and enable the participant to achieve positive personal outcomes.

1912.5 CST services provide intensive behavioral and psychiatric supports for participants who are at imminent risk of institutionalization. The CST is a specialized professional treatment team that consists of a psychologist, psychiatrist, licensed independent clinical social worker, advance practice registered nurse, licensed professional counselor, registered nurse, and/or behavior management specialist, as needed. The most clinically appropriate CST member(s) represents the CST in providing direct services to the participant. Each CST member shall be involved as needed, but CST member(s) shall spend a minimum of one (1) hour weekly meeting with the participant and/or care givers at the onset of treatment. Each CST member shall review summary data at least weekly with other CST staff who are

involved in participant's care. Written behavioral support strategies shall be reviewed and updated at least monthly, based on the participant's response to services.

1912.6 CST services shall include the following services:

(a) Medication/Somatic Treatment services, which may be delivered onsite or offsite;
(b) Crisis/Emergency services, which may be delivered face-to-face or by telephone; and
(c) Assertive Community Treatment (ACT) services, which shall be delivered onsite.

1912.7 CST services shall be authorized and provided in accordance with each person's Individual Habilitation Plan (IHP) or Individual Support Plan (ISP) and Plan of Care.

1912.8 The provider shall provide Medication/Somatic Treatment services in accordance with the Diagnostic Assessment Report.

1912.9 Medication/Somatic Treatment services shall be delivered by the following professionals:

(a) Psychiatrist;
(b) Advance Practice Registered Nurse; or
(c) Registered Nurse.

1912.10 Medication/Somatic Treatment services shall be reimbursed at one hundred twenty-nine dollars ($129.00) per hour. The billable unit of service shall be fifteen (15) minutes at a rate of thirty-three dollars and twenty-five cents ($33.25) per billable unit. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to bill a unit of service.

1912.11 Crisis/Emergency services shall be provided to a participant involved in an active mental health crisis and shall consist of an immediate response to evaluate and screen the presenting situation, assist in immediate crisis stabilization and resolution, and ensure the participant's access to care at the appropriate level.

1912.12 Crisis/Emergency services may be delivered in natural settings and the Crisis/Emergency provider shall adjust its staffing levels, as needed to provide an immediate response. Each Crisis/Emergency provider shall provide consultation, locate other services and resources, and provide written and oral information to assist the participant in obtaining follow-up services.

1912.13 Crisis/Emergency services may be provided based on a recommendation from DDS but shall not be extended beyond ten (10) hours unless the services are included in the Diagnostic Assessment Report.

1912.14 Crisis Emergency services shall be delivered by the following professionals:

(a) Psychiatrist;
(b) Psychologist;
(c) Advanced Practice Registered Nurse;
(d) Licensed Independent Clinical Social Worker; or
(e) A registered nurse, licensed professional counselor, or behavior management specialist working under the supervision of any of the professionals set forth in sections 1912.14 (a), (b), (c) or (d).

1912.15 Crisis/Emergency services shall be reimbursed at one hundred thirty-four dollars and sixteen cents ($134.16) per hour. The billable unit of service shall be fifteen (15) minutes at a rate of thirty-three dollars and fifty-four cents ($33.54) per billable unit. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to bill a unit of service.

1912.16 Eligibility for Assertive Community Treatment (ACT) services is established in the Diagnostic Assessment Report and services shall be provided in accordance with the report. Service coverage by the ACT Team shall be available twenty-four (24) hours per day, seven (7) days per week. After the initial intervention, the ACT Team shall complete a self care-oriented Community-based Intervention plan that focuses on:

(a) Diffusing the current situation to reduce the likelihood of a recurrence;
(b) Coordinating access to mental health services; and
(c) Providing support interventions for participants that develop and improve the ability of parents, legal guardians or significant others to care for the participant in the community.

1912.17 Services offered by the ACT team shall include:

(a) Mental health-related medication prescription, administration and monitoring;
(b) Crisis assessment and intervention;
(c) Symptom assessment, management, and individual support therapy;
(d) Substance abuse treatment for persons with a co-occurring addictive disorder;
(e) Psychosocial rehabilitation and skill development:
(f) Interpersonal social and interpersonal skill training; and
(g) Education, support and consultation to participant's families and/or their support system, which is directed exclusively to the well being and benefit of the participant.

1912.18 ACT services shall be reimbursed at one hundred five dollars and ninety-two cents ($105.92) per hour. The billable unit of service shall be fifteen (15) minutes at a rate of twenty-six dollars and forty-eight cents ($26.48) per billable unit. A provider shall provide at least eight (8) minutes of service in a span of fifteen (15) continuous minutes to bill a unit of service.

1912.19 ACT services shall be delivered by the following professionals:

(a) Psychiatrist;
(b) Registered Nurse: or
(c) Addiction Counselor.

1912.20 Each provider of CST services shall be:

(a) A provider of residential habilitation services as defined in Title 29 DCMR, Chapter 9, Section 946;
(b) A home health agency as defined in Title 29 DCMR, Chapter 19 General Provisions, Section 1903.3;
(c) A provider of supportive living services as defined in Title 29 DCMR, Chapter 9, Section 993; or
(d) A Freestanding Mental Health Clinic as defined in Title 29 DCMR, Chapter 8.

1912.21 Each provider shall have a current Medicaid Provider Agreement that authorizes the provider to bill for CST Services.

1912.22 Each person providing CST services shall have a minimum of two (2) years experience providing professional services to persons with developmental disabilities or receive supervision by professional staff that have the requisite experience. Psychologists shall provide support clinical leadership and provide supports consistent with person-centered practices and positive behavioral support practices.

1912.23 Each person providing CST services shall meet the requirements set forth in section 1911 of Chapter 19, Title 29 DCMR.

1912.99 DEFINITIONS

When used in this section, the following terms and phrases shall have the meanings ascribed:

Addiction Counselor- A person who provides addiction counseling services to persons with co-occurring psychiatric and addictive disorders and is licensed or certified in accordance with applicable District laws and regulations.

Advanced Practice Registered Nurse – A person who is licensed to practice as a registered nurse pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201 *et seq.*), and meets the additional licensure requirements for practice in a particular area as an advance practice registered nurse or nurse-practitioner in accordance with D.C. Official Code § 3-1206.08(a) or (c), or is licensed as a registered nurse and meets additional national certification standards for practice in a particular area as an advance practice registered nurse or nurse-practitioner in the jurisdiction where services are provided.

Assertive Community Treatment (ACT) - An intensive integrated rehabilitative, crisis, treatment and mental health rehabilitative community support provided by an interdisciplinary team to children and youth with serious emotional disturbance and to adults with serious and persistent mental illness. .

Assertive Community Treatment team or ACT Team- The mobile interdisciplinary of qualified practitioners and other staff involved in providing ACT to a participant.

Behavior Management Specialist – A person who has the training and experience in the theory and technique of changing the behavior of individuals to enhance their learning of life skills, adaptive behaviors, and to decrease maladaptive behaviors and works under the supervision of a licensed practitioner.

Community Support Team Services – Services set forth in this section that is designed as an ongoing, preventive service to improve and maintain outcomes in the health, attitude and behavior of the person.

Crisis/Emergency Services- Face-to-face or telephone immediate response to an emergency situation experienced by a participant that is available twenty-four (24) hours per day, seven (7) days per week.

Diagnostic Assessment – Includes (1) indirect assessment techniques such as interviews, written record reviews and questionnaires; (2) direct assessment techniques such as observation of the person, documentation of the frequency, duration and intensity of problem behaviors; and (3) the evaluation of the relationship between the environmental and emotional variables and the occurrence of problem behaviors.

Diagnostic Assessment Report – The report that summarizes the results of the Diagnostic Assessment.

Individual Habilitation Plan (IHP) – That plan as set forth in section 403 of the Mentally Retarded Citizens Constitutional Rights and Dignity Act of 1978, effective March 3, 1979 (D.C. Law 2-137; D.C. Official Code § 7-1304.03).

Individual Support Plan (ISP) – The successor to the individual habilitation plan (IHP) as defined in the 2001 Plan for Compliance and Conclusion of *Evans v. Williams*.

Licensed Independent Clinical Social Worker – A person who is licensed as an independent clinical social worker pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*) or licensed as an independent clinical social worker in the jurisdiction where the services are being provided.

Licensed Professional Counselor- A person who is licensed to practice professional counseling pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*) or licensed as a professional counselor in the jurisdiction where the services are being provided.

Medication/Somatic Treatment – Are medical interventions including: physical examinations; prescription, supervision or administration of mental health-related medications; monitoring and interpreting results of laboratory diagnostic procedures related to mental health-related medications; and medical interventions needed for effective mental health treatment provided as either an individual or group intervention.

Person or Participant – An individual with intellectual and developmental disabilities who has been determined eligible to receive services under the Home and Community-based Services Waiver for persons with Mental Retardation and Developmental Disabilities (Waiver).

Plan of Care – A written service plan that meets the requirements set forth in section 1904.4 of Title 29 DCMR, is signed by the person receiving services, and is used to prior authorize Waiver services.

Psychiatrist – A person who is licensed to practice psychiatry pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*) or licensed as a psychiatrist in the jurisdiction where the services are being provided.

Psychologist – A person who is licensed to practice psychology pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25, 1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*) or licensed as a psychologist in the jurisdiction where the services are being provided.

Registered Nurse – A person who is licensed as a registered nurse pursuant to the District of Columbia Health Occupations Revision Act of 1985, effective March 25,

1986 (D.C. Law 6-99; D.C. Official Code § 3-1201.01 *et seq.*) or licensed as a registered nurse in the jurisdiction where the services are being provided.

Waiver – The Home and Community-based Services Waiver for persons with Mental Retardation and Developmental Disabilities as approved by the Council of the District of Columbia (Council) and the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), as may be further amended and approved by the Council and CMS.

Comments on the proposed rules shall be submitted in writing to Robert T. Maruca, Senior Deputy Director, Medical Assistance Administration, Department of Health, 825 North Capitol Street, N.E., 5th Floor, Washington, DC 20002, within thirty (30) days from the date of publication of this notice in the *D.C. Register*. Copies of the proposed rules may be obtained from the same address.

DISTRICT DEPARTMENT OF TRANSPORTATION

NOTICE OF EMERGENCY AND PROPOSED RULEMAKING

The Director of the District Department of Transportation, pursuant to the authority of section 2 of the Capitol Hill Historic District Protection Temporary Act of 2007, effective October 3, 2007 (D.C. Act 17-122; 54 D.C.R. 10002), and any substantially identical permanent legislation; Mayor's Order 2007-185 (August 9, 2007); Sections 3(b), 5(3), and 6 of the Department of Transportation Establishment Act of 2002, effective May 21, 2002 (D.C. Law 14-137, D.C. Official Code §§ 50-921.02(b), 50-921.04(3), and 50-921.06); Mayor's Order 2007-179 (March 6, 2007); and Sections 6(a)(1), 6(a)(6) and 6(b) of the District of Columbia Traffic Act, approved March 3, 1925 (43 Stat. 1121; D.C. Official Code § 50-2201.03(a)(1), (a)(6) and (b)), hereby gives notice of the intent to amend Chapter 40 of Title 18, "Vehicle and Traffic Regulations," of the District of Columbia Municipal Regulations ("DCMR") by adding three (3) new subsections. The amendments prohibit commercial tour buses in the Capitol Hill Historic District except on certain arterial roads. The rulemaking does not apply to tour buses used for government purposes.

Emergency rulemaking action is necessary due to commercial tour buses parking and idling on narrow residential streets in the Capitol Hill Historic District, which has compromised mobility and accessibility for emergency vehicles and created a public health hazard.

This emergency rulemaking was adopted on December 7, 2007, and became effective immediately on that date. The emergency rulemaking will expire on April 5, 2007, or upon publication of a Notice of Final Rulemaking in the D.C. Register, whichever comes first.

Notice of Emergency and Proposed Rulemaking was published in the D.C. Register on August 24, 2007, at 54 DCR 8382. No comments were received with regard to this rule. One change has been made since publication as a Notice of Emergency and Proposed Rulemaking. The change further defines the term "commercial tour bus" as any motor vehicle used for the transportation of persons for profit that: (1) has a gross weight in excess of twenty-six thousand (26,000) pounds; (2) has three or more axels, regardless of weight; or (3) has a seating capacity of sixteen (16) or more passengers, exclusive of the driver.

The Director also gives notice of the intent to take final rulemaking action to adopt the emergency and proposed rulemaking in not less than ten (10) days from the date of publication of this notice in the D.C. Register. The abbreviated review period is justified because the emergency and proposed rulemaking action will affect a particular group of persons that have been notified and given the opportunity to comment in writing. The proposed rulemaking action is substantially similar to the Notice of Proposed Rulemaking published on August 24, 2007, at 54 DCR 8382.

Title 18 DCMR, Section 4025, **BUS RESTRICTIONS**, is amended to read as follows:

By adding §§ 4025.4, 4025.5 and 4025.6 to read as follows:

4025.4 No person shall operate a commercial tour bus in the Capitol Hill Historic District except upon the following roads:

(a) Pennsylvania Ave., S.E. between 2nd St., S.E. and 13th St., S.E.;
(b) Maryland Ave., N.E. between 2nd St., N.E. and 11th St., N.E.;
(c) Massachusetts Ave., N.E. between 2nd St., N.E. and East Capitol St.;
(d) Massachusetts Ave., S.E. between East Capitol St., and 14th St., S.E.; and
(e) Independence Ave., S.E. between 2nd St., S.E. and 14th St., S.E.

4025.5 Buses used for government purposes and Washington Metropolitan Area Transit Authority buses shall be exempt from the provisions of Subsection 4025.4.

4025.6 For purposes of Subsection 4025.4, the phrase "commercial tour bus" means any motor vehicle used for the transportation of persons for profit that:

(a) Has a gross weight in excess of twenty-six thousand (26,000) pounds;
(b) Has three or more axles, regardless of weight; or
(c) Has a seating capacity of sixteen (16) or more passengers, exclusive of the driver.

All persons interested in commenting on the subject matter of this emergency and proposed rulemaking action may file comments, in writing, with: Ken Laden, Associate Director, Transportation Policy and Planning Administration, District Department of Transportation, 2000 14th Street, N.W., 7th Floor, Washington, D.C. 20009. Comments must be received no later than ten (10) days after the date of publication of this notice in the D.C. Register. Copies of this proposal may be obtained, at cost, by writing to the above address.